



**APPLICATION FOR DISABILITY BENEFITS**  
**1977 POLICE OFFICERS' & FIREFIGHTERS'**  
**PENSION & DISABILITY FUND**

State Form 10564 (R2 / 8-08)

**1977 POLICE OFFICERS' & FIREFIGHTERS'**  
**PENSION & DISABILITY FUND**  
143 West Market Street  
Indianapolis, Indiana 46204-2899  
Toll Free: 1-888-526-1687

\* This agency is requesting disclosure of Social Security Numbers in accordance with IRS code; disclosure is mandatory and this form will not be processed without it.

- INSTRUCTIONS:**
1. Please type or print.
  2. Please submit a copy of the birth certificate. Documents showing the date of birth may be a photocopy of a birth certificate, a baptismal or confirmation certificate, or a court decree. Attach an English translation to any foreign document.
  3. Please have this application notarized.
  4. All of the above items must be provided; this application will not be processed without them.

TO BE COMPLETED BY APPLICANT			
Full name (first, middle, last)		Date of application (month, day, year)	
Address (number and street, city, state, and ZIP code)			
Telephone number ( )		Social Security Number *	Date of birth (month, day, year)
Marital status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Single	If married, name of spouse (first, middle, last)		
Social Security Number of spouse *		Date of birth of spouse (month, day, year)	
Municipality where employed		Municipality account number	Date of hire (month, day, year)
Type of disability <input type="checkbox"/> Converted member <input type="checkbox"/> '77 Fund <input type="checkbox"/> Disabled after left force		Have you received or will you receive any other income while on disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Source of income		Amount of income	

I hereby depose and say that: I am the person who made the foregoing statements; I have carefully read the questions and the answers thereto and understand the same; the information provided is full, complete and true, and no material fact has been concealed or omitted therefrom; and that this application is made for presentation to the board of trustees of the 1977 Police Officers' and Firefighters' Pension and Disability Fund in making claim for the benefits I am entitled to according to 1977 pension fund statutes.

Signature of applicant	Printed name	Date (month, day, year)
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CERTIFICATION OF NOTARY PUBLIC	
STATE OF _____	
SS:	
COUNTY OF _____	
The above information was subscribed and sworn to before me, a notary public, in and for the state and county above named, by the applicant, who is to me personally known, on this _____ day of _____, 20_____.	
Signature of notary public	Printed name of notary public
County of residence	Date commission expires (month, day, year)

TO BE COMPLETED BY LOCAL PENSION BOARD		
Disability period	Last day of full pay from the Department (month, day, year)	Class of disability

**CERTIFICATION OF EMPLOYER**

I hereby certify that the individual named below is a member of the city and department listed below and is covered by the 1977 Pension Fund. I further certify that there is no suitable and available work, considering reasonable accommodations pursuant to the Americans with Disabilities Act (where applicable), for which he/she is or may be capable of becoming qualified. Should this individual return to work, I will notify the 1977 Police Officers' and Firefighters' Pension and Disability Fund in writing.

Name of member ( <i>first, middle, last</i> )		Work status <input type="checkbox"/> Able <input type="checkbox"/> Unable
Department	City	Telephone number (       )
Signature of chief		Date ( <i>month, day, year</i> )

*Please indicate, where appropriate, any employee contributions or employer-paid employee mandatory contributions which have been deducted from pay and are either on a quarterly report in transit or will be reported in the future. **Do not accumulate figures.** Show amounts only by quarter for each quarter still to be reported. Please always indicate this information for the quarter that includes the last day in pay status. **No estimates can be accepted.***

Quarter	Wages Paid	Contribution

I hereby certify the above information for \_\_\_\_\_.  
*Name of employee*

Signature of city controller / clerk treasurer / trustee	Title	Date ( <i>month, day, year</i> )
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